

# **A Program Plan for the Mental Health Cooperative of North Carolina (MHCNC)**

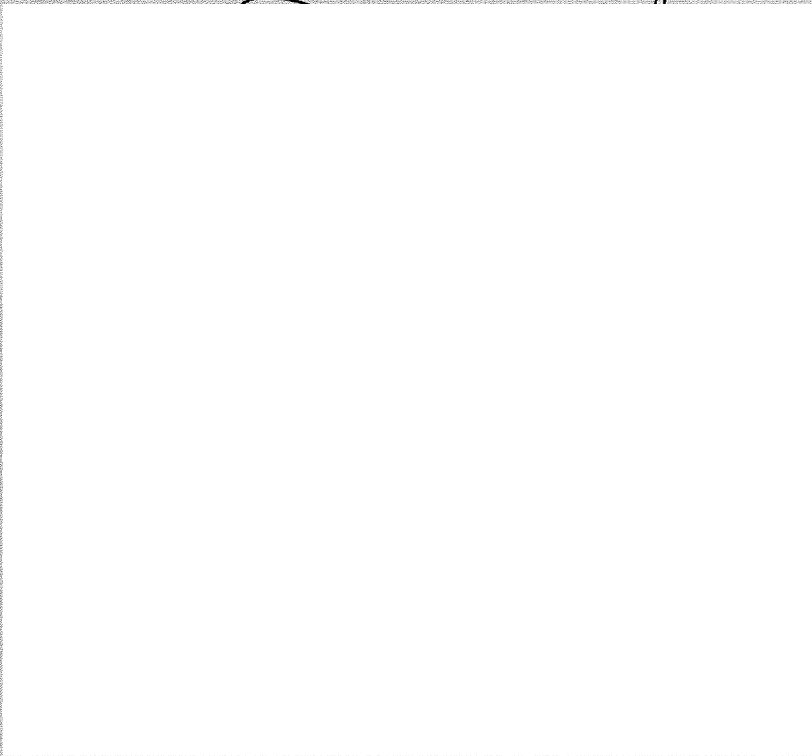
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## **I. Abstract**

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Mental health policy and reform has faced immense transformation since the early 1960s with the passage of law to deinstitutionalize treatment and replace care with more local, community-based treatments and interventions (Rash 2012). While this move has been positive for the state of North Carolina, the transition has not been easy. A historical examination of the state of mental health reform in North Carolina and an evaluation of the system's key stakeholders reveals the ongoing efforts being made to improve the quality of care across the state by means of streamlining of the LME/MCO system. An analysis of the system's strengths and weaknesses further highlights the success of community-based models in behavioral health interventions. Additionally, the paper discusses the need to mitigate fragmented stakeholder involvement, legislative uncertainty, and unsustainable funding. Recognizing the importance of cohesive stakeholder engagement, this paper recommends the establishment of the Mental Health Cooperative of North Carolina (MHCNC or the Cooperative) to augment the already successful work being done by care organizations and nonprofits. The Cooperative's overall goal will be to identify community-based intervention successes across the state, document best practices, and assist care organizations in deploying workable solutions across the state. Underpinning the MHCNC's success are theoretical frameworks and research evidence, such as community-based participatory research and the consolidated framework for implementation research that lend support to the Cooperative's overall goal. While the anticipated outcomes of multilateral models are well documented, there are several limitations to address when assembling community actors. Therefore, it is through effective leadership that the MHCNC aspires to become a compelling advocate in North Carolina's quest to deliver optimal mental health care within its counties.

### III. Introduction: State of Mental Health Reform

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According to the North Carolina Institute of Medicine Task Force on Mental Health and Substance Use (NCIOM Task Force), mental health and substance use disorders are among the top conditions for disability and burden of disease, as well as cost to families, employers, and publicly funded health systems in the United States and worldwide. In 2014, approximately one in five adults in North Carolina had a diagnosable mental, behavioral, or emotional disorder during the past year and one in twelve adults was dependent on or abusing alcohol or illegal drugs (NCIOM Task Force Issue Brief, 2016). North Carolina's public mental health and substance use disorder service system has undergone tremendous and nearly continuous change over the past 15 years. No single agency is in charge of the public system today (NCIOM Task Force Issue Brief, 2016). Indeed, the state of national mental health policy and reform has faced immense transformation since the early 1960s with the passage of law to deinstitutionalize treatment and replace care with more local, community-based treatments and interventions (Rash 2012).

Mebane Rash, CEO and editor-in-chief of Education NC and the North Carolina Center for Public Policy Research (NCCPPR), highlights two significant events that further strengthened the community-based movement in the 1990s. These include: (i) the enactment of the Americans with Disabilities Act (ADA) in 1990 which sought to eliminate discrimination against those with disabilities; and (ii) the *Olmstead* U.S. Supreme Court decision in 1999 that required states to place people with mental disabilities in the least restrictive setting possible and in community settings rather than in institutions. This decision paved the way for mental health reform nationwide (Rash 2012). Mebane notes that, between 2001 and 2011, the number of persons served at the state's psychiatric hospitals declined from more than 17,000 people to fewer than

to concerns that the private sector might not be sufficiently responsive to the needs of people with mental illness and that the profit motive could result in a reduction in the quality or quantity of services, particularly for those with severe and persistent mental illness (Rash 2012). According to the NCIOM Task Force 2016 Issue Brief, the “system” includes a variety of fragmented providers and services, which contributes to unnecessary disability, school failure, homelessness, and incarceration. Besides the consolidation of LMEs and the increasing the population of people requiring services, the strain on mental health care is also being driven by payment policies that result in disparities, or significant gaps, in access to quality interventions, treatment, and recovery across the state. For instance, one critical weakness in the system is the heavy reliance on inpatient services. In their 2016 Issue Brief, the NCIOM Task Force highlights the need for more preventative and other community-based approaches that can decrease the need for higher levels of care and provide more balance to the system. Further, the Task Force acknowledges that such system balance will not occur without additional resources in the short-term to support the lower levels of care prior to recommending any sort of reductions to the funding earmarked for the higher levels of care (i.e. inpatient services).

Therefore, in order to achieve a less fragmented system of privatization in the arena of mental health care within North Carolina, key stakeholders must support new models of reaching consumers of mental health care services. Desired outcomes for mental health illness will require a multifaceted approach. In order for this restructuring to run more efficiently, a development of a strategic, comprehensive, and interdisciplinary public health program plan is required to ensure that North Carolina’s mental health reform agenda operates at an optimal level. This paper will discuss the array of improvements across the state in the area of public

times, unexpected changes in response to fiscal and political constraints. This lack of stability in the governance structure has presented challenges as key stakeholders and health care providers work to improve the level of desired outcomes. According to Rash, North Carolina's reform effort has seen major changes in policy, funding levels, and leadership so frequently that often it seems the biggest problem with reform is the lack of consistency, or as Rash puts it the "state's inability to stay the course – any course. More than a decade after reform legislation passed in North Carolina, significant changes are still underway" (Rash 2012). Based on the NCCPPR's research and analysis of mental health reform across the United States, the key to building a solid mental health system is settling on a strategy, implementing it, evaluating it, and sustaining the reform through stable funding over the long term.

*b. Funding*

Funding for mental health care within the state is derived from multiple sources that include the state general fund, federal block grants, special purpose grants from the federal government and private foundations, county appropriations, client fees, and federal Medicaid.

Bluestein identifies Medicaid and the state general fund as the largest sources of revenue for community-based services for those eligible to receive Medicaid funds and for those not eligible for Medicaid and without access to third-party insurance, respectively. To illustrate, Bluestein presented a breakout of authority budgets for the Cardinal Innovations area authority and the CenterPoint Human Services. In 2013, Cardinal Innovations, an area authority covering fifteen counties reported \$356 million in budgeted revenues for fiscal year 2012–13, 80 percent of which came from Medicaid. CenterPoint Human Services, an area authority serving four counties, reported that 62 percent of its budgeted revenue came from Medicaid (Bluestein 2014). In 2012, Rash noted the "new funding model" being tried out in North Carolina. It was known

### *c. Care Organizations*

Arising from the mental health reforms in the state emerged the Critical Access Behavioral Health Agencies (CAHBAs), which underpinned a new provider model in North Carolina. These large providers ensure appropriate medical and clinical treatments and aim to reduce the potential for ineffective or unwarranted services. As of August 2012, there were 210 certified CABHAs statewide (Rash 2012). As discussed earlier, the Medicaid Waiver program allows LMEs, formerly known as area authorities, to choose providers and manage budgets in order to provide MH/DD/SA services. In this regard, CAHBA providers may be chosen to ensure delivery of care. According to Rash, CABHAs may be for-profit, nonprofit, or public health agencies, but they are required to provide three core services – comprehensive clinical assessment, medication management, and outpatient therapy – and at least two additional services from a list of 14 services, creating a continuum of care. The goal is to establish a strong clinical foundation on which to build community capacity.

While the goal with the “new funding model” was to expand the Medicaid Waiver to one or two LMEs annually and affording LMEs the time to develop the expertise as well as allowing the state time to learn from each implementation, the rising costs of Medicaid in 2011 amid declining state revenues due to the recession forced the state legislature to pass a bill to expand the waiver by July 1, 2013. Further rapid expansion of LMEs led to another wave of consolidation of LMEs into managed care organizations (MCOs). “The managed care organizations, formerly called local management entities, are regionally based and will remain so under the new alignment, with one in the east, two in the central region and one in the west.” (Sisk, 2013). See the Exhibit 1 below for the nine LME/MCOs that were providing services as of April 2014.

mental illness. Other organizations that complement the statewide initiatives include religious institutions, behavioral health agencies, and mental health associations.

## **V. Strengths and Weaknesses of Current System**

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### *a. System Strengths*

Each year, North Carolina's *Transition to Community Living Initiative (TCLI)* is evaluated by an independent reviewer. The June 2013 North Carolina Training, Instruction, Development, and Education (NC TIDE) publication highlighted the TCLI, which is an 8-year plan guided by the principles of the ADA and the 1999 *Olmstead* U.S. Supreme Court decision. The TCLI's goal was to move at least 3000 individuals in North Carolina from a state psychiatric hospital or Adult Care Home (ACHs) (NC TIDE, 2013). The latest report the independent reviewer in the matter of the United States of America vs. the State of North Carolina, released October 1, 2016 by Martha B. Knisley had a few glimmers of good news.

(i) *Deinstitutionalization and LME-MCO framework*: According to the Knisley, while the he State is making slow and still somewhat uneven progress, the TCLI program funding requests have been honored by the Governor and Legislature and TCLI, DHS leadership and LME/MCO leadership is strong (Knisley 2016).

(ii) *Capitated Funding Model*: Versus fee-for-service (FFS) models, capitation offers more financial certainty to providers of mental health services. A study by the Health Research and Education Trust revealed that "a capitation model with a for-profit element was more cost-effective for Medicaid patients with severe mental illness than not-for-profit capitation or FFS models (Grieve 2008).

(iii) *Community-based treatments on the rise*: Bluestein highlights the progress made over the years as a result of the deinstitutionalization reform in North Carolina. The percentage of

access to providers of care services. This weakness appears contrary to the ambitions of the area authority solutions that culminated in the LME-MCO frameworks. The Task Force suggests that key stakeholders and policymakers first recognize that North Carolina's complex mental health system is not well understood. Consequently, the state leaders and other actors must improve the awareness and education needed to improve understanding and access.

(iii)*Unstable Funding*: According to the Task Force, the current state funding for mental health and substance abuse treatment services does not adequately meet the mental health and substance use treatment and recovery needs of the uninsured and underinsured. In her article, *North Carolina's Mental Health System: Where We Have Been, Where We Are, and Where We Are Headed*, published in *North Carolina Insight*, Rash discusses this issue of unstable funding within the state. While more than \$3 billion is spent each year on services, the reformed system has been on a roller coaster ride of state funding, with the Great Recession taking its toll on North Carolina's state budget revenues and thus funding for the system. State funding for the division of MH/DD/SA totaled \$581 million in fiscal year (FY) 2001–02, increased to \$743 million in 2008–09, decreased to \$664 million in 2009–10, increased to \$705 million in 2010–11, decreased to \$666 million in 2011–12, and increased to \$696 million in 2012–13. In order to provide a more continuous stream of improvements within the state, access to funds are crucial. As mentioned earlier under our discussion of funding, the reliance on Medicaid is high a direct contrast from the case in 1986, where Medicaid ranked lower nationally than state and local governments, private insurance, and patients as payers for mental health care. According to Bluestein, because Medicaid is the largest single source of revenue for



(v) *Leadership Turnover*: High turnover in any institution hinders the continuity of the strategic vision and progress being made by leadership. Perhaps a direct result of the instability of ongoing reform is a direct result of the high turnover of leadership. For instance, Rash noted that approximately 61 legislators serving in 2011–12 were anticipated not to be returning at all or to the same chamber in 2013 as a result of deaths, resignations, redistricting, or defeats in the 2012 elections. This will result in a loss of institutional memory around the goals of mental health reform and create another hurdle for stable funding and consistent policies (Rash 2012).

## **VI. Recommendation Of Program Initiative**

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To complete a meaningful strategic planning process, a systematic evaluation of the current environment is necessary. As we highlighted earlier in the *Mental Health System: Key Stakeholders* section above, the regulatory framework within the state experienced frequent changes since 2001. Since then, the lack of stability in the governance structure has presented challenges as key stakeholders and health care providers work to improve the level of desired outcomes. The constant policy changes and leadership turnover presents a unique opportunity for public-private partnerships to combat the unfortunate impact of these realities on the delivery of quality care to people suffering with mental illness in our state. Based on the analysis of the current system's strengths and weaknesses conducted above, the following program will be presented.

In order to augment the already successful work being done by care organizations and nonprofits, the establishment of the Mental Health Cooperative of North Carolina (MHCNC or the Cooperative) is recommended. The MHCNC's overall goal will be to identify community-based intervention successes across the state, document best practices, and assist care

practices by county that will help form the basis of the MHCNC's formal recommendations over time.

(iii) *Identify MHCNC Long-Term Vision*: Within the first year, the MHCNC staff officials will identify the key areas of focus for the upcoming year and long-term vision arising from the data gathering process and in accordance with the mission statement and Cooperative's by-laws. Among our near-term ideas are pursuing opportunities to introduce the MHCNC to the public by forming partnerships with county mental health associations, other non-profits, LME-MCOs as these organizations also seek engagement from the public. The Cooperative will identify a campaign that is easily communicated to a wide audience like Healthy People 2020, where we identify desirable outcomes in for North Carolina's mental health care system over time.

(iv) *Independent Evaluation of MHCNC*: Within the first two years, the MHCNC will have completed an interim analysis of program activities and an independent review of the group's performance by a third-party program evaluator to help us understand our strengths as a group and opportunities to create meaningful impact. In the same period, we will bring together focus groups to assess general attitudes and beliefs about the Cooperative's agenda and activities. At the end of two years, we expect the MHCNC to have partnered with one or two other mental health-focused organizations and participated in at least two community outreach events each quarter.

### ***Long - Term Goals***

(i) *Expanding beyond Raleigh-Durham*: Within three to five years, we hope to have expanded the MHCNC to all 4 counties under the purview of the Alliance Behavioral

## ***Theoretical Frameworks***

As this paper discusses the need to adequately and collaboratively engage stakeholders it is vital that we also convey the theories underpinning the success of this initiative. The following two theories should be examined as part of the implementation of this initiative and accomplishment of these goals.

*Community-Based Participatory Research (CBPR):* CBPR within the most recent decades has been recognized as a unifying research approach that looks to bridge the gap between science and applied health through mobilizing community engagement while also placing an emphasis on a call for action amongst all applicable stakeholders (health advocates, community participants, governmental entities, health agencies, etc.) to improve the way we provide health services (Wallerstein, Durran 2006). Ten years ago, the Institute of Medicine (IOM) recommended CBPR as one of eight new areas in public health education (Faridi, Grunbaum, Gray, Franks, Simoes 2007). CBPR advocates for communicative public health sectors to develop, implement, and provide effective interventions to diverse communities. This approach studies the way we analyze and implement strategies on a population level that address the ways in which access to health services, and specifically with regard to this paper, how mental health services can be easily accessed, and adequately provided to targeted populations in need of mental health assurance. Through engagement with public health administrators, community leaders, and other stakeholders, our goal would be to understand the shortcomings of the LMEs and CMOs that look to provide mental health services and improve upon their previous efforts (Wallerstein, Durran 2006). CBPR approach is informative and compatible with the MHCNC's goals as the approach demonstrates that engagement with communities helps better direct and design of the program plan. However, research evidence suggests that there are some structural

developing a vigorous and distinguishable program plan is to accurately assess whom the program will be serving. For example, if the program has participants who have various socio-economic limitations that hinder their ability to seek and obtain mental health assistance, the program planner must define how this community will be serviced and will the attempts to alleviate these limitations improve the likelihood of this type of community participating in the program. As a program planner, one will have to assess a number of factors. Some of these include; “Who will be participating? What interests are being served or not served? If community members are participating, in which aspects are they participating and in which decisions is there little participation? How do we address the reality that different stakeholders may and do have different goals of participation and different knowledge needs, and may and do have different expertise to participate more actively at different stage? (Wallerstein, Duran 2006). These types of questions must be acknowledged when considering the diverse nature of the cultural and social needs of the targeted interest group (Wallerstein Duran 2006).

With underprivileged health populations, the challenge is to ensure that the primary health issues affecting both health status and health disparities are being addressed (Wallerstein Duran 2006). Furthermore, given the unfortunate historical ethical occurrences, such as the Tuskegee syphilis experiment, understandably a significant amount of distrust towards the health providers – researchers (Wallerstein Duran 2006). There is no choice but to recognize that elements of privilege, race, and various levels of socio-economic status do play a role in the degree to which researchers are able to connect with these populations (Wallerstein Duran 2006). Ultimately, a program plan that relies heavily on the input of the community would need to identify structural changes that support engagement with the community (Wallerstein Duran 2006).



The intervention construct focuses on strengthening of evidenced-based interventions. Outer and inner setting place a high emphasis on the patient's need's and leadership engagement. The "individual" component is primarily concerned with the characteristics of an individual. Lastly, the "process" component is described as how a program will plan and execute the desired program objectives (Damschroder, Aron, Kirsh, Alexander, Lowery 2009). As mentioned above, the CFIR can be used as an implementation guide for researchers to collect qualitative findings. With regards to the MHCNC, the CFIR would serve as a useful tool for program planners to conduct in-depth interviews that are designed to ask specific questions that would affect diverse communities. Further, these questions prevent program planners from deviating from their initial and desired program objectives. Additionally, the analysis and coding of these interviews may also help re-direct our program focus as often times a program planner will find that desired objectives of the program may have to be reassessed per the sentiments expressed by the participants of the program (Mack, MacQueen, Guest, Namey, 2011).

### *Implementation*

Our implementation plan will focus on the near-term objectives leading to the formation the MHCNC. We will utilize a project timeline with milestones as well as a logic model to provide a visual map for the founding team. These illustrations will assist officials and volunteers to understand the key tasks, deadlines, and objectives that are necessary to accomplish in order to reach our overall goals. A sample project timeline and logic model is presented in Appendix A and Appendix B, respectively. An interim operating budget will also be presented while the Cooperative aims to secure grants and awards targeted at supporting the work of public health nonprofits. The following opportunities for funding were located on the website of the North Carolina Community Health Center Association (NCCHCA). The NCCHCA is a valuable

<b>Interim Operating Budget</b>		<b>Year 1</b>	<b>Year 2</b>
<b>Revenue</b>			
<b>Grant 1</b>		\$10,000	\$15,000
<b>Grant 2</b>		5,000	10,000
<b>Donations/Fundraising</b>		\$5,000	8,000
<b>Cash/Savings</b>		-	2,000
<b>Total Revenue</b>		\$20,000	\$35,000
<b>Expenses</b>			
<b>Office Rent &amp; Utilities</b>		-	(9,600)
<b>Salary &amp; Wages</b>		-	-
<b>Legal, Tax, and Accounting</b>		(10,000)	(10,000)
<b>Job Posting/HR</b>		(3,000)	(3,000)
<b>Office Supplies &amp; Stationary</b>		(2,000)	(3,000)
<b>Food &amp; Beverage</b>		(2,000)	(4,000)
<b>Transportation</b>		(1,000)	(3,000)
<b>Total Expenses</b>		(18,000)	(32,600)
<b>Net Income</b>		2,000	2,400

### *Evaluation*

Beyond monitoring health metrics and statistics in the state and working to meet the Cooperative's long-term goals described above, the MHCNC will evaluate its success by ensuring that the recommendations adopted by our care organization partners are routinely monitored, and consistently evaluated against their established program goals. The successful completion of a project will be measured through periodic interim analysis ensuring that the core objectives of the mental health initiative are being met. As the broader goals of the Cooperative are evaluated, it will also be vital to work with program planners at various levels of the care organizations or provider networks to actively assess whether or not the established goals at the start of the project are still meeting the intended objectives of the chosen initiative. The *SMART Behavior Change Outcome* tool can prove to be beneficial as it specifies the kind and amount of change one can expect to achieve for a specific population within a given timeframe (Rubin 2017).

Health Project, a program with a demonstrable intervention effect and part of the national “5 a Day” campaign to promote consumption of fresh fruits and vegetables. The success of the program was attributed to its multilevel approach and use of qualitative information from the study population to design culturally sensitive programs and messages (Merzel & D’Afflitti, 2003).

Although not exhaustive, the Cooperative anticipates to be able to yield the following outcomes:

- Achieve improved coordination and cross-system collaboration to ensure that information, policies, procedures, and funding are better coordinated to meet the needs of those suffering with mental illness.
- Identify the percentage of treatments at community-based facilities and improve or maintain to be in line with statewide levels around 90 percent of total treatments (also in line with observing decreases in the need for higher levels of care or inpatient services).
- Increased access to information and improved knowledge of policy initiatives, LME/MCO frameworks, and payment options for providers, patients, and caregivers.
- Decrease in the stigma associated with preventative mental health care.
- Improve the overall quality of health. This may be measured by monitoring such indexes as those published by the *County Health Rankings & Roadmaps* program, a collaboration between The Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, which helps communities identify, and implement solutions that make it easier for people to be healthy.

community. If explicitly stated compromises can be reached the partnership should proceed. If not, perhaps this is not a good collaboration at this time (Freeman et al., 2006).

*Building true partnerships:* The experience of the community partners is that they are often approached to participate projects that have been conceived academic researchers, often in an area of their expertise and driven by the grant requirements and guidelines of the funding agency. For instance, in the case of the Healthy Public Housing Initiative (HPHI), a community-based project started in 2001 in Boston; while the project was informed to a significant extent by community interests, community partners almost always found themselves advocating principles of partnership at every table at which they sat. Further, with policymakers, donors, academic researchers, and healthcare providers on the same team, it is conceivable to understand how challenging it would be to foster equity amongst partners in the Cooperative. To foster the necessary partnerships, teams must consider organizational tools such as mission statements and organizational by-laws to adhere to as they work towards the overarching goal of improving mental health outcomes. Furthermore, members must work to dispel and overcome stereotypes about one another.

*Overcoming negative stereotypes:* According to research by Freeman and colleagues, academic researchers may have beliefs that their community partners lack the infrastructure and capacity to be full partners in achieving the research aims of the project, which can immediately contribute to tensions and power differentials because academic researchers may be uncomfortable ceding control over any aspects of the project (Freeman et al., 2006). In HPHI, tensions between public housing residents trained to work as community health advocates (CHAs) and individuals with formal academic training arose throughout the project when it came to data collection because CHAs placed greater trust in the community partners while individual



community health assessments and partnering with care organizations to implement effective interventions that address the health needs among various populations.

## **VIII. Conclusion**

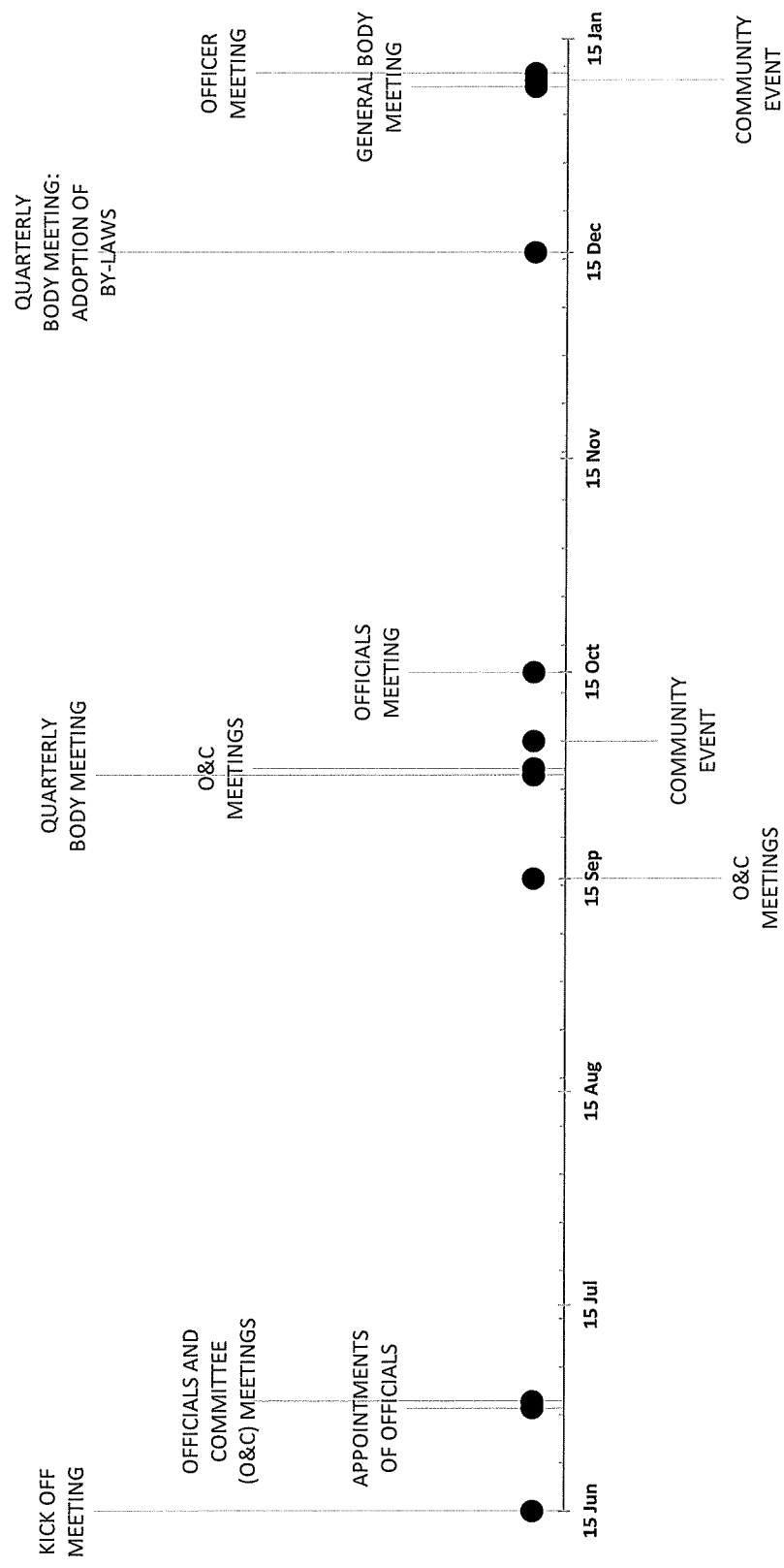
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This paper has examined the state of mental health care in North Carolina by charting the history of mental health reform and evaluating the strengths and weaknesses of the current system. In discussing the key stakeholders that play an active role in the delivery of care, an understanding of the legislative environment, the care organizations, the funding mechanisms, and community associations that support the system has been developed. Based on the analysis of the system's strengths and weakness, potential solutions will be identified by the Cooperative to achieve desired mental health care outcomes in North Carolina by drawing from the experiences, knowledge, and skills of a diverse group of community actors. An examination of the role that theoretical frameworks such as CBPR and CFIR can play in facilitating partnerships within the state's LME/MCO framework to ensure program plans are implemented, sustainable, and supported by evidence-based research. Various implications of the program initiative have also been discussed: among them, desired outcomes such as improving coordination and cross-system collaboration amongst stakeholders to meet the needs of those suffering with mental illness, demonstrating the benefit of community-based interventions, and improving the overall quality of health. Recognizing the limitations of community-based approaches such as misaligned stakeholder objectives, difficulty in achieving equity in partnerships, and a tendency for stakeholders to stereotype one another negatively, an appreciation of organizational dynamics and personality traits amongst team members must be stressed. It is through this kind of effective collaboration and leadership, that the MHCNC will become a compelling advocate in North Carolina's quest to deliver optimal mental health care within its counties. As Kenny

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# Sample Timeline for Formation of MHCNC



## Appendix B: Logic Model

